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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on October 18, 2010 through October 22, 2010, in accordance with 42 CFR Chapter IV Part 483 Requirements for Long Term Care Facilities. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, action, or other claims for relief that may be available to any party under applicable federal, state, or local laws. The census was 216 residents. The sample size was 30 residents, which included three closed records. There was one unsampled resident. Two complaints were investigated during the recertification survey: Complaint #NV00026623 alleged the facility was not taking steps to prevent a fall, and not properly assessing the resident after the fall. These allegations were not substantiated through clinical record review, document review, and interviews with facility staff. Complaint #NV00026689 alleged lack of sufficient staffing and was not substantiated through observations, document review, and interviews with facility staff. The following regulatory deficiencies were identified:	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	Continued From page 1 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff members provided care and services in a manner that enhanced residents' dignity and assured residents' privacy. Findings include: On 10/20/10 in the morning during the group interview, four residents indicated the residents were "treated like children" by the nurses. The four residents stated new nurses who didn't know their conditions acted like they were all incontinent, and they had been checked for bladder incontinence while they were sleeping. Some of the residents' statements included the following: "I don't like being woken up in the middle of the night with a nurse trying to check my diaper. It only happened once, and then I told them not to wake me up anymore." "I'm not even incontinent, and they checked me for being wet." "They try to check my diaper in the morning before I'm even awake." Another resident indicated she was approached by a physical therapist that morning, who took her blanket off of her legs without her permission. The resident stated she did not want her blanket	F 241		

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taken off, but the therapist had said, "I want to see what pants you are wearing." and took the blanket off anyway.

During a resident interview on 10/20/10, the resident indicated a nurse who worked the evening shift did not like it if a resident who was dependent in transferring from the bed to the wheelchair asked to get up again, stating, "She (the nurse) does not like it if you ask to get up again. Once you're in bed at night, you're in bed for the whole night."

Resident #23

Resident #23 was admitted 5/13/10 with diagnoses including hypertension, benign prostatic hypertrophy, hyperlipidemia, episodic mood disorder, and psychosis.

On 10/22/10 in the morning, Resident #23 was interviewed. Resident #23 indicated he liked to talk and hold hands with a female resident while sitting at the table in front of the dining room. He stated, "The nurses are very strict here. I think they let the power go to their heads. I like to hold hands with the lady who lives in the room across the hall and they tell me I can't do that. We just like to hold hands and pass the time of day. I have never done any more than hold hands with her, and I would never do that. This one nurse tells me to go to my room whenever she sees me holding her hand. I don't understand why we can't hold hands. Once when I got into an argument in the dining room with a man who lives here, this nurse told me, 'Go to your room and stay there until I come get you.' I stayed in my room for a long time, and she never came to my room. I finally walked out of my room even though she

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told me not to, and when I looked around, she was nowhere to be found. She would have never come back for me. I don't like being in my room very much. I can understand how in the morning I need to stay in my room until they give me my medications. But I'm a very social guy and I like to see what's going on. I like it here and I don't want them to kick me out."

On 10/20/10 in the afternoon, the Director of Nursing (DON) indicated that Resident #23 and #24 just hold hands while sitting in front of the dining room, no more than holding hands. The DON further stated that both families were aware and agreeable to the friendship and holding hands. The DON stated all of the nurses and staff should know holding hands was okay.

On 10/21/10 in the afternoon, the 100 Hall Charge Nurse indicated Resident #23 was allowed to hold hands with Resident #24, but will "try to discourage it because other female residents get jealous". The nurse further stated both residents' family members were notified and were in agreement for the residents to hold hands.

On 10/22/10 in the morning, the Human Resources Director indicated Resident #23 was not allowed to hold hands with Resident #24. When the Human Resources Director walked by and saw Resident #23 holding hands with Resident #24, she told the residents not to, and revealed sometimes it was necessary to separate the residents because they kept holding hands.

Review of Nurse's Notes in Resident #23's file revealed the following:
7/3/10 - 12:30 PM: "Rec'd (received) report from

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F 241	Continued From page 4 LPN (licensed practical nurse) of verbal altercation between res (resident) in which this pt (patient) was involved (with) exchange of words (with) 2 other male res during lunch. Separated and easily redirected." 7/3/10 - 1330 (1:30 PM): "Notified of activities will be monitored q (each) 15 minutes and meals will be served in rm (room) to prevent further occurrence of altercation, pt in agreement stating that, 'I love it here and don't want to get put out!'" 7/3/10 - 2:00 PM: "...15 minute checklist completed during shift. Son called x2 to reinforce staying in his room to eat meals and be on good behavior concerning peer interaction." 8/29/10 1800 (6:00 PM): "In room, watching TV. Son notified and made aware of incident and said resident can eat meals in his room for 2 weeks..." 8/31/10: After meeting (with) this resident yesterday (with) social worker resident was educated over and over re (regarding) his physical and verbal behavior to the opposite sex. He is being redirected to his room (after) being seen (with) female residents in the foyer area. He was seen telling another female resident to go to the bench where they always sit today 8/31/10. " was made to the son re the meeting that transpired yesterday...Resident had been redirected several x (times) today." 9/27/10 - 1340 (1:40 PM): "Spoke (with) resident r/t (related to) holding hands (with) female resident and he is ok with it; they are friends and nothing more." 10/19/10 - 1100 (11:00 AM): "...Resident redirected to his room and reeducation. Placed on alert charting for behavior. Care plan updated." During a resident interview on 10/20/10, the resident indicated the nurses frequently yell at Resident #23 in front of the dining room and tell	F 241		

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F 241	Continued From page 5 him, "Go to your room." Resident #26 Resident #26 was re-admitted to the facility on 7/22/10, with diagnoses including acute renal failure, diabetes, and dysphagia. During observation of the lunch meal on 10/19/10 at 12:05 PM, Employee # 4 stood to feed Resident #26. On 10/21/10 during the breakfast meal, Employee # 4 stood, leaning against the wall, to feed Resident #26. On 10/21/10 at 7:20 AM, Employee #7, a Registered Nurse, was working on the 100 Hall. She was heard to sternly tell a resident, "Go to your room." The resident then went to her room and Employee #7 took the resident's blood pressure.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under	F 279		

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F 279	Continued From page 6 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to develop, review, revise, and/or consistently implement a plan of care for 3 of 30 sampled residents (Residents #9, #25, and #26). Findings include: Resident #9 Resident #9 was admitted to the facility on 3/9/99, and re-admitted on 5/11/09, with diagnoses including urinary tract infection, chonic airway obstruction, and difficulty swallowing. During September 2009, the resident was placed on services with (Hospice A). A review of Resident #9's record indicated the resident had 13 care plans. For all the interventions on all the care plans, there was no documentation Hospice A's staff had roles in providing care to achieve the goals of the care plans. On 10/20/10 at 8:40 AM, Employee #5 was unable to show how the 13 care plans were coordinated plans of care between the facility and Hospice A. Employee #5 found a hospice plan of care for Resident #9 in the back of the resident's record, not under the care plan section. The	F 279		

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hospice plan of care was developed on 9/9/09. There was no documentation on the care plan of revisions since the plan was developed.

The hospice agreement between the facility and Hospice A signed by both parties on 1/17/07, read, "2.2 Design and Maintenance of Plan of Care. (a) Initial Plan of Care. In accordance with applicable federal and state laws and regulations, Hospice shall coordinate with Facility to timely develop a Plan of Care for each new Hospice Patient. Hospice shall furnish Facility with a copy of the Plan of Care within twenty-four hours of its completion. (b) Modifications. The Plan of Care will be updated by the Interdisciplinary Group weekly or more often as necessary. Hospice will consult and coordinate with Facility, with respect to any modifications to the Plan of Care, and will provide Facility with a copy of any modifications to the Plan of Care within twenty-four hours of its completion."

Resident #25

Resident #25 was admitted to the facility on 10/3/08, and re-admitted on 4/22/10, with diagnoses including respiratory insufficiency, difficulty swallowing, and pneumonia. On 5/4/10, the resident was placed on services with (Hospice B).

A review of Resident #25's record indicated the resident had 15 care plans. For all the interventions on all the care plans, there was no documentation Hospice B's staff had roles in providing care to achieve the goals of the care plans. There was no documentation of a hospice plan of care found in the resident's record.

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The hospice agreement between the facility and Hospice B signed by both parties on 4/22/10, read, "2.2 Design and Maintenance of Plan of Care. (a) Initial Plan of Care. In accordance with applicable federal and state laws and regulations, Hospice shall coordinate with Facility to timely develop a Plan of Care for each new Hospice Patient. Hospice shall furnish Facility with a copy of the Plan of Care within twenty-four hours of its completion. (b) Modifications. The Plan of Care will be updated by the Interdisciplinary Group weekly or more often as necessary. Hospice will consult and coordinate with Facility, with respect to any modifications to the Plan of Care, and will provide Facility with a copy of any modifications to the Plan of Care within twenty-four hours of its completion."

Resident #26

Resident #26 was re-admitted to the facility on 7/22/10, with diagnoses including acute renal failure, diabetes, and dysphagia. On the quarterly Minimum Data Set assessment reference dated 8/1/10, the facility documented the resident required "extensive assistance of one person" for eating. The facility developed a care plan in regards to the resident's need for assistance. Approaches included, "Allow resident ample time to consume food. Provide assistance as needed (cueing, feeding assist)."

During observation of the lunch meal on 10/19/10 at 12:05 PM, Employee #4 fed Resident #26. When Employee #4 left to assist another resident, Resident #26 picked up the glass of juice on the tray and independently drank the glass of juice without difficulty. On 10/20/10 during the lunch meal, Employee #4 fed the resident. When the

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F 279	Continued From page 9 employee left, the resident picked up a glass of water and independently drank the water without difficulty. On 10/21/10 at 7:45 AM, Employee #4 stated, "(Resident #26) sometimes feeds herself. She has to be reminded to slow down. She can feed herself when she wants, but we just like to feed her." On 10/22/10 during the breakfast meal, Employee #4 cued Resident #26 to pick up the spoon and begin eating. Resident #26 properly held the spoon and fed herself a bite of food. Employee #4 left to assist another resident. After a few spoonfuls of food, Resident #26 stopped eating. Two facility staff were sitting at the table assisting other residents. Neither of the staff members cued Resident #26 to continue eating. After six minutes, Employee #4, who was seated at a nearby table, cued Resident #26 to continue eating. On 10/22/10 at 9:45 AM, the Director of Nursing indicated staff should allow Resident #26 to feed herself as much as possible. The facility failed to consistently implement the plan of care for Resident #26 to maintain her highest practicable level of independence in self-feeding.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309		

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F 309	Continued From page 10 and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to ensure: 1) processes were systematically coordinated by the disciplines responsible for diet ordering - nursing, speech, nutrition - in order to prevent inaccurate diet orders for 1 of 30 residents (Resident #17); 2) tube feedings were administered as ordered for 1 of 30 residents (Resident #16); and 3) hospice services were effectively integrated into the plan of care for 2 of 30 residents (Residents #9 and #25). Findings include: Resident #17 Resident #17 was admitted to the facility on 9/16/10, with diagnoses including pulmonary emboli, chronic kidney disease, dysphagia, and debility. Review of the resident's record revealed an admission diet order of NAS (no added salt) mechanical soft, with NTL (nectar thick liquids). The kitchen staff received this order through a Diet order and Communication slip provided by nursing. On 9/17/10, the diet tech's nutritional progress note included the following documentation: "Recommend D/C (discontinue) current diet. Change to NAS mechanical with NIP (nutrition intervention program - fortification of foods)...vitamin C fortified juice 2 times daily." This was written as an order on 9/24/10, but there	F 309		

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was no evidence that kitchen staff received this updated order from nursing.

On 9/20/10, a Speech Therapist wrote the following order: "D/C mechanical soft consistency, begin regular consistency. D/C nectar thick liquids, begin thin liquids. Continue with all other dietary recommendations." When the nursing staff transcribed this order to the Diet Order and Communication form (for kitchen staff) on 9/20/10, the phrase 'continue with all other dietary recommendations' was left out.

In an interview with the Dietary Director on 10/21/10 at 11:00 AM, the Director communicated that when she received the Diet Order and Communication form nursing on 9/20/10 which read, "Regular consistency/thin liquids," she believed this meant the resident was now supposed to receive a regular diet, without the other dietary recommendations of NIP and fortified juice.

Review of Resident #17's record revealed that as of 9/20/10, the resident was receiving a regular diet with thin liquids without NIP, when the actual diet order was NAS diet with thin liquids with NIP (and fortified juice 2 times daily). Nutritional progress notes, dated 9/24/10, 9/27/10, 10/1/10, 10/5/10, 10/8/10, and 10/20/10, revealed the diet technicians and dietitian were under the assumption the resident was receiving a NAS diet with NIP and fortified juice. The resident's care plan and weekly IDT (interdisciplinary) notes (the most current being 10/19/10) still indicated the resident was receiving a NAS mechanical soft diet with NIP and NTL.

Resident #16

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Resident #16 was initially admitted to the facility on 8/16/10, with readmission on 10/15/10. Diagnoses included debility, congestive heart failure, sacral pressure ulcer, dementia, seizure disorder, atrial fibrillation, and dysphagia. The resident had a gastrostomy tube (g-tube), with an enteral admission order of Glucerna 1.2 infused at 75 cc (cubic centimeters) per hour over 20 hours daily.

On 10/18/20, the diet tech made the following recommendation: "1) D/C current H20 (water) flush; 2) start H20 150 ml (milliliters) every 4 hours; 3) D/C current g-tube feeding; 4) start Glucerna 1.2 250 ml every 4 hours via g-tube pump at 300 ml per hour (1500 = 1800 kcals (calories), 90 grams protein); 5) MVI (multivitamins) with minerals via g-tube once daily; 6) med flush 30 ml water before, 5 ml between, and 30 ml after medication administration."

This new diet recommendation was transcribed by nursing as a telephone order on 10/19/10. When it was transcribed by nursing to the resident's medication administration record (MAR), the 150 ml water flushes were included in the Glucerna bolus feeding order. Five times were listed on the MAR: 8:00, 12:00, 16:00, 20:00, and 24:00, starting on 10/19/10. According to the order, six feedings, not five, were required to meet the resident's nutritional needs. Because the 150 ml water flushes were not written separately on the MAR, there was no way to determine if the flushes were administered.

On 10/20/10 at 2:20 PM, a Unit Nurse Manager,

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Employee #3, was interviewed. The employee confirmed there should have been six bolus feeding times listed on Resident #17's MAR. The nurse further agreed the 150 ml water flush order should have been written separately on the MAR.

The facility's "Physician Orders/Transcription" policy, dated 10/04, included the following standard: "Proper channels of communication are used to ensure accurate delivery of medications and treatments to all residents. This is achieved by using the Order Sheet, Telephone Order Form, MAR, and Treatment Record."

Resident #9

Resident #9 was admitted on 3/9/99, and re-admitted on 5/11/09, with diagnoses including urinary tract infection, chronic airway obstruction, and difficulty swallowing. During September 2009, the resident was placed on services with Hospice A.

A review of Resident #9's record indicated the resident had 13 care plans. For all the interventions on all the care plans, there was no documentation Hospice A's staff had roles in providing care to achieve the goals of the care plans.

On 10/20/10 at 8:40 AM, Employee #5 was unable to show how the 13 care plans were coordinated plans of care between the facility and Hospice A. Employee #5 found a hospice plan of care for Resident #9 in the back of the resident's record, not under the care plan section. The hospice plan of care was developed on 9/9/09. There was no documentation on the care plan of

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F 309	Continued From page 14 revisions since the plan was developed. The hospice agreement between the facility and Hospice A signed by both parties on 1/17/07, read, "2.2 Design and Maintenance of Plan of Care. (a) Initial Plan of Care. In accordance with applicable federal and state laws and regulations, Hospice shall coordinate with Facility to timely develop a Plan of Care for each new Hospice Patient. Hospice shall furnish Facility with a copy of the Plan of Care within twenty-four hours of its completion. (b) Modifications. The Plan of Care will be updated by the Interdisciplinary Group weekly or more often as necessary. Hospice will consult and coordinate with Facility, with respect to any modifications to the Plan of Care, and will provide Facility with a copy of any modifications to the Plan of Care within twenty-four hours of its completion." Resident #9's record failed to show documented evidence of a calendar from Hospice A which indicated the days of the month any Hospice A staff would visit the resident and provide care. A facility generated care plan for Resident #9 for the problem of "Terminal diagnosis: End Stage Dementia, comfort care only" indicated the hospice aide was to visit two times a week on Tuesdays and Fridays to provide assistance with Activities of Daily Living (ADL) care. On 10/20/10 at 8:30 AM, the facility Certified Nursing Assistant (CNA) identified as providing care for Resident #9, stated the hospice aide came "on Monday and Thursday" to provide care for Resident #9. The CNA indicated she was unaware of a calendar from hospice which indicated when the hospice aide visited.	F 309		

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A review of the hospice aide's visit notes filed in Resident #9's record for 10/01/10 through 10/12/10 revealed the hospice aide visited as follows:
-Friday, 10/1/10;
-Wednesday, 10/6/10;
-Thursday, 10/7/10; and,
-Tuesday, 10/12/10.

On 10/20/10, Employee #5 stated, "There isn't a calendar for hospice visits. The care plan has the nurse visits once a week and the aide visits twice a week."

The facility failed to have a system in place to ensure the care provided for Resident #9 by the facility and Hospice A was coordinated between the two to meet the resident's needs.

Resident #25

Resident #25 was re-admitted to the facility on 4/22/10, with diagnoses including respiratory insufficiency, difficulty swallowing, and pneumonia. On 5/4/10, the resident was placed on services with (Hospice B).

A review of Resident #25's record indicated the resident had 15 care plans. For all the interventions on all the care plans, there was no documentation Hospice B's staff had roles in providing care to achieve the goals of the care plans. There was no documentation of a hospice plan of care found in the resident's record.

The hospice agreement between the facility and Hospice B signed by both parties on 4/22/10, read, "2.2 Design and Maintenance of Plan of Care. (a) Initial Plan of Care. In accordance with

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applicable federal and state laws and regulations, Hospice shall coordinate with Facility to timely develop a Plan of Care for each new Hospice Patient. Hospice shall furnish Facility with a copy of the Plan of Care within twenty-four hours of its completion. (b) Modifications. The Plan of Care will be updated by the Interdisciplinary Group weekly or more often as necessary. Hospice will consult and coordinate with Facility, with respect to any modifications to the Plan of Care, and will provide Facility with a copy of any modifications to the Plan of Care within twenty-four hours of its completion."

Resident #25's record failed to show documented evidence of a calendar from Hospice B which indicated the days of the month any Hospice B staff would visit the resident and provide care. A facility generated care plan for Resident #25 for the problem of "receiving hospice due to end-stage debility" indicated the hospice aide was to visit three times a week on Mondays, Wednesdays, and Fridays to provide assistance with Activities of Daily Living (ADL) care. The hospice Registered Nurse (RN) was to visit three times weekly on Tuesday, Thursday and Friday.

On 10/21/10 at 12:30 PM, the facility Certified Nursing Assistant (CNA) identified as providing care for Resident #25, stated the hospice aide came "on Thursday" to provide care for Resident #25. The CNA indicated he "floated" to the unit on Thursdays and provided care to Resident #25 and would see the hospice aide at that time.

A review of the hospice aide's visit notes filed in Resident #25's record indicated the following hospice aide visits from Hospice B:
-Wednesday, 9/1/10;

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F 309	Continued From page 17 -Thursday, 9/2/10; -Saturday 9/4/10, -Tuesday, 9/7/10; -Thursday, 9/9/10; -Friday, 9/10/10; -Wednesday, 9/15/10; -Thursday, 9/16/10; -Saturday, 9/18/10; -Thursday, 9/23/10; -Friday, 9/24/10; -Saturday, 9/25/10; -Wednesday, 9/29/10; and, -Thursday, 9/30/10. Hospice B aide's visit notes filed in Resident #25's record for October were: -Saturday, 10/2/10; -Thursday, 10/7/10; -Friday, 10/8/10; -Saturday, 10/9/10; -Tuesday, 10/12/10; -Thursday, 10/14/10; -Saturday, 10/16/10; and, -Thursday, 10/21/10. Hospice B's RN visited Resident #25 on: -Monday, 8/23/10; -Friday, 8/27/10; -Monday, 8/30/10; -Wednesday, 9/8/10; -Tuesday, 9/14/10; -Tuesday, 9/21/10; -Wednesday, 9/29/10; and, -Tuesday, 10/5/10. A Hospice B RN documented on a hospice form on 10/14/10, the hospice nurse would visit Resident #25, "1-3 x (times) week." The box for the frequency of visits for the hospice aide was	F 309		

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F 309	Continued From page 18 blank. There was no documented evidence in Resident #25's record to indicate the facility was aware of the change in visit days by Hospice B's nurse. There was no documentation to explain if the blank for the frequency for the hospice aide indicated the aide would no longer visit to provide care or the form was incomplete. The facility failed to ensure services provided by Hospice B were coordinated with the facility to ensure the resident received all services necessary to promote comfort and maintain the highest practicable level of function.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services according to the plan of care to maintain eating skills for 1 of 30 sampled residents (Resident #26). Findings include: Resident #26 Resident #26 was re-admitted to the facility on 7/22/10, with diagnoses including acute renal failure, diabetes, and dysphagia.	F 311		

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F 311	Continued From page 19 The quarterly Minimum Data Set assessment reference dated 8/1/10, indicated the resident required "extensive assistance of one person" for eating. The facility developed a care plan in regards to the resident's need for assistance. Approaches included, "Allow resident ample time to consume food. Provide assistance as needed (cueing, feeding assist)." During observation of the lunch meal on 10/19/10 at 12:05 PM, Employee #4 fed Resident #26. When Employee #4 left to assist another resident, Resident #26 picked up the glass of juice on the tray and independently drank the glass of juice without difficulty. On 10/20/10 during the lunch meal, Employee #4 fed the resident. When the employee left, the resident picked up a glass of water and independently drank the water without difficulty. On 10/21/10 at 7:45 AM, Employee #4 stated, "(Resident #26) sometimes feeds herself. She has to be reminded to slow down. She can feed herself when she wants, but we just like to feed her." On 10/22/10 during the breakfast meal, Employee #4 cued Resident #26 to pick up the spoon and begin eating. Resident #26 properly held the spoon and fed herself a bite of food. Employee #4 left to assist another resident. After a few spoonfuls of food, Resident #26 stopped eating. Two facility staff were sitting at the table assisting other residents. Neither of the staff members cued Resident #26 to continue eating. After six minutes, Employee #4, who was seated at a nearby table, cued Resident #26 to continue eating.	F 311		

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F 311	Continued From page 20 On 10/22/10 at 9:45 AM, the Director of Nursing indicated staff should allow Resident #26 to feed herself as much as possible.	F 311		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and document review, the facility failed to ensure staff followed universal precautions and clean technique when giving medications through a gastrostomy tube (GT) to minimize the potential for complications for 1of 6 sampled residents with GTs (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 6/8/98, and re-admitted on 12/2/09, with diagnoses including cancer of the stomach and altered mental status. The resident received enteral feedings, hydration, and medications through a GT. On 10/20/10, during the morning medication pass, Employee #6 was observed administering	F 322		

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medications through the GT to Resident #8. After preparing the medications, Employee #6 indicated she would check the GT for placement to ensure it was in the stomach. Employee #6 handled the GT without washing her hands or donning gloves.

After administering the medications, Employee #6 removed the large syringe from the connector of the GT. During the process, Employee #6 dropped the syringe on the floor. Employee #6 capped off the GT, placed the dirty syringe on the counter by the sink in the resident's room, and left the room to get a new large syringe.

Upon returning with another syringe, Employee #6 opened and handled the clean syringe without washing her hands. The employee donned gloves without washing her hands. Employee #6 prepared to provide water via gravity flow through Resident #8's GT. The employee removed the plunger from the large syringe and placed it on the table at the resident's bedside without placing it on a clean area. After giving the water, the employee capped off the GT, removed her gloves, washed her hands, and exited the room leaving the dropped syringe on the sink counter, and the contaminated syringe plunger on the bedside table.

Outside Resident #8's room, when questioned about the aforementioned observations, Employee #6 indicated she should have washed her hands upon entering the room and donned gloves prior to handling the GT. The employee acknowledged the plunger of the clean syringe should have been placed in the clean package the syringe came in and she should have placed the dropped syringe in the red sharps container

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F 322	Continued From page 22 before leaving the resident's room. The facility's (undated) policy titled, "Enteral Nutritional Therapy (Tube Feeding)" read, "...General Infection Control Guidelines: 1. Observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee. 2. Wash your hands before and after all procedures. Wear gloves when appropriate ..." The facility's (undated) policy titled "Feeding Tube-Instilling Medication" indicated an employee was to wash hands before and after administration of medication, but did not address the use of gloves. On 10/22/10 at 10:00 AM, the Infection Control Coordinator (ICC) related the facility's practice was to wear gloves when handling a GT at any time. The ICC further indicated employees should wash their hands before donning gloves and after removing the gloves. The ICC was shown the facility's policy regarding the instillation of medications through a GT and stated, "It should include directions to wear gloves." Cross-reference Tag F441	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and document review, the facility failed to ensure supervision to prevent accidents by keeping a resident's smoking implements at the nurses' station (Unsampled Resident #31).

Findings include:

Resident #31

Resident #31 was admitted to the facility on 12/13/02 with diagnoses that included hypertension, diabetes, and below the knee amputation.

On 10/21/10, Resident #31 communicated he did not want staff members to take his cigarettes and lighters.

On 10/21/10, the facility's undated policy titled "Smoking," was reviewed. The document read, "Residents' smoking materials will always be kept at the nurses' station on the unit and only given to residents by staff ... There will be strict adherence to this policy and all efforts to ensure this policy will be documented in the residents' charts. Violations will result in: ...Possible discharge of residents who do not comply."

On 10/21/10, Resident #31's clinical record was reviewed and his "Smoking Safety Assessment" was reviewed. The document indicated the resident was assessed for his ability to safely smoke on 04/09/10, 07/01/10, and 10/02/10.

The "Assessment" portion of the document

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F 323	Continued From page 24 consisted of six questions. One of the questions was, "4. Does resident attempt to keep smoking paraphernalia on self or in room?" The 04/09/10 and 07/01/10 assessments indicated "yes," Resident #31 did keep his smoking paraphernalia on himself or his room. On 10/22/10 at 9:00 AM, Employee #12, a Registered Nurse, stated she documented the assessments on 04/09/10 and 07/01/10, and knew Resident #31 kept his cigarettes and lighter in his room or in his pocket. The Administrator, Employee #1, was interviewed on 10/21/10 at 4:00 PM and reported Resident #31 gave his cigarettes and lighter to staff members and the items were being stored in a locked room.	F 323		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food was maintained at proper temperatures before the meal service.	F 371		

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F 371	Continued From page 25 Findings include: During a tour of the kitchen with the Assistant Dietary Director on 10/19/10 at 8:45 AM, three containers were observed on the counter with the following labels written on the foil coverings: "pureed meat," "pureed bread," and "pureed vegies." There was no indication as to when the pureed foods were prepared. A temperature check revealed the meat (pureed ground beef) was 129.8 degrees Fahrenheit (F), the bread (with added milk) was 98.1 degrees F, and the vegetables were 127.4 degrees F. The cook who prepared the pureed foods explained she was planning to leave the containers on the counter until 10:00 AM, and then put them into the oven in preparation for lunch service. In response to this explanation by the cook, the Assistant Dietary Director indicated the correct food preparation procedure was to prepare the pureed foods closer to the time of the meal service, so that food temperatures would not remain in the danger zone for bacterial growth. According to the facility's "Food Temperature Control" policy, dated 1/1/07, "Food temperatures are maintained during serving times to ensure residents receive safe food served at acceptable temperatures...Guideline: Hot foods are held at a minimum of 140 degrees F or higher and cold foods at or below 40 degrees F."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425		

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F 425	Continued From page 26 them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to have a system in place to ensure expired medications were not available for use in the Pyxis (automated medication storage and dispensing system). Findings include: During observation of the morning medication pass on 10/20/10, Employee #6 did not have the medication Aldactone available for administration to Resident #8. The employee called the pharmacy and was told the medication was available in the facility's Pyxis system. A facility authorized licensed nurse accessed the Pyxis system and removed a single packaged	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF LAS VEGAS	6151 VEGAS DRIVE LAS VEGAS, NV 89108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 27 dose of Aldactone 25 milligrams (mg) from the system. Upon inspection of the package, the expiration date of 9/30/10, was noted on the package. The Director of Nursing (DON) entered the medication room with the Pyxis system at 10:30 AM and was told of the findings. The DON accessed the system and found all the single packaged doses of Aldactone 25 mg had expired on 9/30/10. While the Pyxis drawer was opened, a random sampling of three other medications found all the doses of Omeprozole 20 mg and Metoprolol 25 mg had expired on 9/30/10. The DON was unable to recount what process was used to ensure expired medications were not available for distribution in the Pyxis system. The DON stated, "Pyxis use is fairly new to us. I will call the pharmacy immediately." On 10/20/10 in the late afternoon, a pharmacy representative indicated the Pyxis system was relatively new to the pharmacy staff. The representative further explained the pharmacy was in control of all the reports which could be generated by Pyxis and just recently discovered a report regarding expired medications in the facility's system could be generated. The representative recounted what process the pharmacy immediately instituted with this incident, but was unable to state what process was in place prior to the discovery. A review of the pharmacy's policy used by the facility, titled "6.5 Automated Medication Dispensing System" with an effective date of 12/01/07, failed to outline a process to identify expired medications in the system.	F 425		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 28 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff followed universal precautions and clean technique when giving medications through a gastrostomy tube (GT) to minimize the potential for infection for 1 of 6 sampled residents with GTs (Resident #8). Findings include: Resident #8 Resident #8 was admitted to the facility on 6/8/98, and re-admitted on 12/2/09, with diagnoses including cancer of the stomach and altered mental status. The resident received enteral feedings, hydration, and medications through a GT. On 10/20/10, during observation of the morning medication pass, Employee #6 administered medications through the GT to Resident #8. After preparing the medications, Employee #6 indicated she would check the GT for placement to ensure it was in the stomach. Employee #6 handled the GT without washing her hands or donning gloves. After administering the medications, Employee #6 removed the large syringe from the connector of the GT. During the process, Employee #6 dropped the syringe on the floor. Employee #6 capped off the GT, placed the dirty syringe on the counter by the sink in the resident's room, and left the room to get a new large syringe. Upon returning with another syringe, Employee #6 opened and handled the clean syringe without	F 441		

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F 441	Continued From page 30	F 441		

washing her hands. The employee donned gloves without washing her hands. Employee #6 prepared to provide water via gravity flow through Resident #8's GT. The employee removed the plunger from the large syringe and placed it on the table at the resident's bedside without placing it on a clean area. After giving the water, the employee capped off the GT, removed her gloves, washed her hands, and exited the room leaving the dropped syringe on the sink counter, and the contaminated syringe plunger on the bedside table.

Outside Resident #8's room, when questioned about the aforementioned observations, Employee #6 indicated, she should have washed her hands upon entering the room and donned gloves prior to handling the GT. The employee acknowledged the plunger of the clean syringe should have been placed in the clean package the syringe came in and she should have placed the dropped syringe in the red sharps container before leaving the resident's room.

The facility's (undated) policy titled, "Enteral Nutritional Therapy (Tube Feeding)" read, "...General Infection Control Guidelines: 1. Observe (standard) universal precautions or other infection control standards as approved by appropriate facility committee. 2. Wash your hands before and after all procedures. Wear gloves when appropriate ..."

The facility's (undated) policy titled "Feeding Tube-Instilling Medication" indicated an employee was to wash hands before and after administration of medication, but failed to include the use of gloves.

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F 441	Continued From page 31 On 10/22/10 at 10:00 AM, the Infection Control Coordinator (ICC) related the facility's practice was to wear gloves when handling a GT at any time. The ICC further indicated employees should wash their hands before donning gloves and after removing the gloves. The ICC was shown the facility's policy regarding the instillation of medications through a GT and stated, "It should include directions to wear gloves." Cross-reference Tag F322	F 441		